CALIFORNIA RURAL HEALTH POLICY COUNCIL
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California Rural Health Policy Council
Public Meeting Summary
March 1, 2007
Hyatt Regency – Sacramento

Chairperson

Stephen Mayberg PhD, Chairperson
Director, Department of Mental Health

David Carlisle, MD, PhD,
Director, Office of Statewide Health Planning and Development

Renee Zito, LMSW, CASAC
Director, Department of Alcohol and Drug Programs

Sandra Shewry, MPH, MSW
Director, Department of Health Services

Lesley Cummings
Executive Director, Managed Risk Medical Insurance Board

Bonnie Sinz, Division Chief
Emergency Medical Services

Council Staff

Kathleen Maestas, Rural Health Program Administrator

Raylynn Sanders, Rural Health Office Manager

Chair's Report: Stephen Mayberg PhD
Chairperson Mayberg outlined the structure of the meeting then moved on to general introductions beginning with the newest director, Renee Zito, Department of Alcohol and Drug Programs.

Council Member Zito shared a brief history about herself by way of introduction then proceeded to the program updates.

PROGRAM UPDATES

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
Renee Zito, LMSW, CASAC, Director

- Methamphetamine Public Awareness Campaign
  1. $10 Million in funding per year for three years approved by Legislature and the Governor
  2. The department requested and received 8 proposals from public relations and advertising firms which are currently under review.. Based on these proposals, ADP plans to name 2 contractors by late March as follows:
     a. One Public relations
     b. One Advertising
  3. This Awareness Campaign will target "high risk" populations, including;
     a. Women of childbearing years
     b. Men who have sex with other men

- ADP created a Methamphetamine Practitioner's Guide that includes:
  1. Overview of Methamphetamine
  2. Assessment, treatment and how to deal with Methamphetamine
  3. High risk populations/special populations;
     a. HIV/AIDS
     b. Latino
     c. Adolescents
     d. Women
  4. The Methamphetamine Practitioner's Guide will be sent to all clinicians and treatment programs in the state

- Substance abuse prevention and treatment.
  1. Pilot program to continue
  2. Small counties can continue to exchange 'set aside' funding with substance abuse, prevention, and treatment discretionary funding
  3. Small counties will have more flexibility in meeting their client's needs

4. Prior to the fund exchange, many of the counties were having difficulty expending their substance abuse prevention and treatment categorical funds

- Bill AB 631 (Mobile Narcotic Treatment Program) was signed into law last year.
  1. This program expands access to Methadone treatment programs for heroine addiction. ADP will license these programs.
  2. Clients have greater access to treatment
  3. It reduces spread of communicable diseases and other health risks associated with addiction
  4. ADP is currently developing regulations for the program

Emergency Medical Services
Bonnie Sinz, Division Chief

- Statewide trauma planning assessment and future direction document
  1. Approved by the Governor in December, 2006
  2. EMS is currently looking at the next steps for implementation
  3. California is being regionalized due to the size of the state; there are currently 6 regions
  4. EMS hopes to assist smaller rural hospitals to become designated as Level 3 or Level 4 trauma centers
  5. There are currently 4 levels
     a. UC Davis is a Level 1
     b. Community hospitals are a level 2

- Transportation program
  1. The 31 local EMS agencies are being surveyed to ascertain:
     a. What providers they have
     b. What is their role as far as transport versus first responder
     c. What their capabilities are
     d. existing resources as far as ambulance transport and fire first responders

- EMS for children project
  1. EMS is working on/finalizing the guidelines that will effect the rural area
  2. Emergency Department for the care of pediatric patients' guidelines are based on the American Association of Pediatrics document to help hospitals at all levels, rural and urban
  3. EMS is currently looking at pediatric equipment for our basic life support and advance life support response units
  4. EMS is also looking at the care of pediatric trauma patients and non-pediatric trauma centers

5. Field treatment protocols that the paramedics currently utilize in the care of kids in the field are being revamped

- 10th Annual EMSA Conference
  1. EMS is currently in preparations for the conference and entitling it "It's a Small World"
  2. Conference will be in Southern California this year
  3. EMS is offering rural scholarships for pre-hospital personnel to have all expenses paid to go to these conferences

- EMS Data System is in the final stages. EMS will be able to collect statewide data on EMS incidents throughout the state

- Statewide Trauma Registry is being developed; EMS will have information on all trauma patients at Level 1 through 4 trauma centers

- EMS Personnel Programs for the rural area. EMT 2 regulations are being revised. Information is available on the website. This would allow local EMS agencies to have an EMT 2 program based on their community needs.

- Rural AED (Automatic External Defibrillator Program) has had a significant reduction in funds. EMS did not apply this year due to staffing shortages but hopes to apply again in the future.

- Disaster
  1. EMS is purchasing personnel protective equipment for our EMS providers through the local EMS agencies
  2. EMS purchased DASU's (Disaster Ambulance Support Units) to be available to the local areas in case of a disaster
  3. EMS has CALMAT's or Disaster teams which are personnel and cash equipment that will respond to areas in the event of a disaster
  4. EMS have a registration process starting up for volunteers throughout the state in the event of a disaster
  5. EMS is purchasing 3 Mobile Field Hospitals which can be dispatched throughout the state in the event of a disaster

DEPARTMENT OF HEALTH SERVICES
Tom McCaffery, Chief Deputy Director

- Healthcare Reform Proposal
  1. Wellness and prevention and healthy lifestyles
     a. MediCal program – DHS would like to provide rewards/incentives to engage our beneficiaries in healthy lifestyles to participate in early screenings for particular ailments

b Statewide initiative on diabetes – Administration would like to convene a work group of stakeholders to help inform the final designs of the initiative. One piece of that will include the MediCal Program and what can be done in the delivery system to screen, prevent, and better self-manage diabetics and those with pre-diabetic conditions.

c Combating obesity – DHS will be working with communities to provide better access to healthy foods and physical activity in terms of parks, etc. mass public education and awareness, about lifestyle and behavior

d Tobacco Control – Increased investment and access to cessation; providing smoking cessation classes and other resources to combat tobacco use

e Universal coverage for all residents of the State of California requires shared responsibility

i MediCal would have a large role in covering uninsured individuals; over 200,000 uninsured children and 600,000 uninsured adults.

ii There would be an expansion in healthy families and subsidized coverage for individuals not qualified for MediCal or Healthy Families, these expansions would be jointly financed by the state and federal government

iii Providers would have more paying patients

iv There would be an increase in MediCal rates to both hospitals and physicians recognizing that an increase in rates will help stabilize the provider network

v Providers and hospitals would pay a fee on their gross revenue, 4% for hospitals and 2% for physicians

- Hospital Demonstration Waiver
  1. The State receives 180 million dollars from the federal government each year. DHS has received proposals from individual counties and consortia counties with a plan to cover the indigent adults in their jurisdiction for the final 3 years. DHS expects to announce those awards later this month.

- Food-born illnesses
  1. The Governor proposed a two million dollar general fund investment to increase the capacity of both the department and local jurisdictions which would seek to enhance the department's capacity to have emergency response to investigate, detect and close out investigations of food born illness and expand our capacity to train and lend support to local jurisdictions in investigating retail food-born illness incidents

- Surge Capacity Project is a six-month project to focus on investing the state and local capacity to respond to public health emergencies. We are working with outside stakeholders to develop standards and guidelines.

- The Governor signed legislation that will split DHS and create a Department of Public Health. As of July 1, 2007, DHS will be split in two; one department will be focused on public health and one on healthcare services. There will be more focus on the respective areas of the two departments, more ability to focus on implementation of programs and initiatives, and most importantly more accountability and better outcomes. There will be a progress update by the next meeting.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
David Carlisle, MD, PhD, Director

- OSHPD has been very active in terms of making the plan review process as efficient as possible, not just for seismic safety but for all plan review activity for California Hospitals and skilled nursing facilities.

- HAZUS Program is a program whereby OSHPD will be re-evaluating the seismic performance status of hospital buildings throughout California using state-of-the art methodology and standards. John Gillengerten, our new acting director of our Facilities Development Division has been running our program for the last six months very successfully.

- OSHPD's Workforce division awarded over three million dollars to nurse training programs in the State, some that serve specifically rural areas. The director of that division is Angela Minniefield.

  This is a major program that is funded from Governor Schwarzenegger, through the Work Force Investment Act money, recognizing the great need for increased numbers of registered nurses in California.

- The office released its second hospital performance report on Community Acquired Pneumonia this week. This report is referred to by some as a report card for hospitals. It places hospitals in three performance strata in terms of how they treat patients who are admitted to the hospital with pneumonia that isn't already outside the hospital. The report can help patients make informed decisions about their healthcare choices and give hospitals the opportunity to evaluate and improve their quality of care.The report is available on the OSHPD website.

- The Cal-Mortgage program within OSHPD exists to extend funding and capital to not-for-profit healthcare facilities of every type, most importantly to improve access to healthcare.

- OSHPD has a new Assistant Director for Legislative and Public Affairs, Patrick Sullivan; he is from the Office of Assembly member Dr. Keith Richmond. He has been with OSHPD for a month.

MANAGED RISK MEDICAL INSURANCE BOARD
Ron Spingarn, Deputy Director, Legislation & External Affairs

- MRMIB is currently funding 66 Rural Health Demonstration Projects statewide. The Governor's budget for the coming fiscal year is at 5.8 million which is roughly the same level that MRMIB has received in the past.

- MRMIB's Healthy Families Program is the largest SCHIP program in the state second only to MediCal. Funding expires at the end of September; consequently, MRMIB is closely monitoring the federal legislation to reauthorize or renew the funding for all 50 states. MRMIB is currently trying to figure out how much the whole country needs, the hope is that there will be approximately 50 billion dollars reauthorized for all 50 states which would allow MRMIB to continue the current funding programs to not change the eligibility, which is 250 percent of the federal poverty levels. We are hoping to get double our current allocation to maintain our current eligibility levels. If the President's proposal to reduce eligibility levels to 200 percent goes through, several hundred thousand children in California would become ineligible or be wait-listed.

- There are several proposals for healthcare reform that would increase the eligibility level to 300 percent of the federal poverty level. Many of them involve the MRMIB board and programs and focus on the explanation of High Risk or the Healthy Families programs. MRMIB is working with the members of the legislature to insure that MRMIB will be involved.

- The major risk medical insurance pool which is for folks who cannot get insurance in the private sector because of pre-existing health conditions. There is currently a pilot project that allows us to eliminate the wait list for the Major Risk Medical Insurance pool expires this year. There is a bill pending (AB2) by Assembly member Dymally which would create a fee for the health plans. Currently the funds for that program are through the tobacco tax which is not enough for MRMIB to eliminate the wait list, so it is hoped that AB2 will pass which would result in the elimination of the wait list.

DEPARTMENT OF MENTAL HEALTH SERVICES
Stephen Mayberg PhD, Director

- 47 of the 58 counties have contracts with DMHS for what is called community service and support

- Education and training
  1. The department would prefer to have those activities in places like schools and primary care where almost everybody has access
  2. There is a need to do training for our partners and provide capacity building for everyone involved in the lives of the individuals who are part of our system

- Prevention and early intervention
  1. The work force is not available to provide the services needed. This is most prevalent in rural areas and in 24 hour care facilities.
  2. The key needs:
     a. Eliminate disparities in access
     b. Trauma and how it shows up in our mental health system, the vets who are returning and the number of children and adults who have been traumatized by what's going on in their life.
  3. Stigma and discrimination
  4. Suicide Rate – more than twice as many people die of suicide in the U.S. than die of homicide. The State is going to take the lead on suicide prevention and on stigma and discrimination reduction. There is also a need to do training, not to the mental health field but for our partners and provide capacity building for those that will be involved in the lives of individuals who are part of our system.
  5. Priority populations – Focus on un-served cultural populations.
     a. 50% of the money is going to go to kids in transition-age youth
     b. Quicker responses to people who have first breaks. Currently the duration of untreated time between someone who has first symptoms of a psychosis to the time of treatment is anywhere from 18 months to 3 years. A person who has symptoms of a neurosis, the average time between they show symptoms and receive treatment is 5 years.

  6. Culturally specific interventions. We are examining the barriers besides language that will make a difference in terms of earlier access and better outcomes.
  7. We'd like to set up an evaluation. We believe prevention is the way to go, not the fail-first system that we currently have.

RURAL HEALTH POLICY COUNCIL
Kathleen Maestas, Programs Administrator

- RHPC website is the number one way of communicating with rural constituents; it is constantly being updated and will soon be redesigned according to the Governor's office approved web redesign format. This will improve the delivery of cross agency information and services to its key stakeholders. Over the last 6 months, the website has averaged over 30,000 hits from rural constituents statewide and nationally. The most frequently viewed page is the jobs available page. Several pages have been added to our website and many updates have been made.

- RHPC has been involved in the Rural Work Force Collaborative that was convened by CSRHA, the Statewide Collaborative of 20 key stakeholder organizations of diverse background is including advocacy, education, technology, economic and state work force programs. Another collaborative includes the California Healthcare Association, the California State Rural Health Association, OSHPD, the Rural Health Policy Council and the Department of Health Services to discuss the possible revision or update of the rural hospital definition.

- The Governor signed an order to clear the red tape on building a broad band network. Jeff Newman, the Technology and Commerce Partnership Manager for the California Business Transportation and Housing Agency and the architect of the California Broad band initiative is here to give us an overview on the activities of implementing that executive order.

CALIFORNIA BUSINESS TRANSPORTATION AND HOUSING AGENCY
Jeff Newman, Technology and Commerce Partnership Manager

- The broadband task force is comprised of 21 very engaged pragmatic leaders. We want to create a cycle between availability of broadband, the use of it and its application. There are 6 working groups that underlie the work of the task force:
  1. Health care
  2. Economic development
  3. Build out or technical architecture
  4. Emerging technology and new applications
  5. Community development and foundations
  6. Education

- We have the following 8 objectives:
  1. Accelerate access to primary and specialty care at a lower cost
  2. Increase access to primary and specialty care at a lower cost
  3. Create a sustainable technical connection between rural underserved communities and medical centers of excellence

4 Create technical organization collaborations between rural underserved communities and medical centers of excellence
5 Identify community regional and state level stakeholders
6 Identify short and midterm
7 Focus on top healthcare issues or chronic diseases
8 Include a list of challenges to implementation

- During the summer, **California Business Transportation and Housing Agency** are going to be compiling best approaches for collaborative actions and delivering it to the task force at the end of October.

PUBLIC TESTIMONY

Cathy Martin, Director, California State Rural Health Association

- Wants to make sure that the programs that are in place that currently serve medically underinsured areas remain in place.
- Reformed proposals that are to be considered must allow these populations to fully realize the benefits of any health reform.
- Coverage is one piece of a bigger puzzle, comprehensive reform must build the capacity of rural healthcare provides through infrastructure funding, work force initiatives and expanded access to information technology.
- CSRHA intends to provide a voice for rural so that the unique perspectives are communicated to opinion leaders and law makers and the administration.

Christine Scully, California Health Facility Financing Authority (CHFFA) of the State Treasurers Office

- We are a state agency that provides 3% interest loans to non-profit small and rural health facilities under our 'Help To Loan' Program. We also do bond issues.
- CHFFA recently added the rural health facility as an eligible borrower.
- Increased the maximum loan from $500,000. to $700,000.

Gail Nickerson, Adventist Health

- Clinics that provide primary care services but are not "primary care clinics" according to California's definition. Many hospitals have one or more clinic and there is no definition of these provider based clinics in California regulation. Neither OSHPD nor DHS could track the number or list these clinics across the state. Laws passed that support primary care clinics, do not apply to most of these clinics because legislators don't know that hospital based clinics are not primary care clinics by definition.
- Where do we take our concerns and begin the process of defining what a Rural Health Clinics is and how it is different from a primary health clinic?

Christina Bivona-Tellez

- Could the person from the Department of Health Services address the goals to reduce the barriers of integrating both the behavioral health issues and the physical health issues so that they may be addressed simultaneously.

Joe Rogers

- Is there anything related to seismic beyond the hazardous program?
- Is there any assistance from the state being considered for seismic retrofit?

Charla Parker

- What studies have been done to show how many hospitals would be able to keep their doors open after they had to give 4% of their gross revenues that is proposed in the Governor's Healthcare Reform Proposal for universal coverage?

Kevin Erich, Frank R. Howard Memorial Hospital

- We are in the process of building a new hospital and costs continue to escalate. Is there something that can be done to try to help legislatively or some other way to try to get additional funding or at least reduced cost funding for small hospitals?
- Is there any way we could get some kind of temporary waivers on the OSHPD requirements for the current hospital since we are in the process of building a new one?

Sneha Patel, UC Davis Medical Center

- We have a program called 'Rural Prime' that is adding up to 12 new students to our medical school class and we are training them in a specially tailored program to try to get them into rural areas and medically underserved areas. We hope to train them in tele-medicine and the use of technology so that they can go to rural areas and feel that they have access to specialist care in the urban areas.
- I'd like you to speak to me if you are interested in eventually partnering with us to get our students out to you for preceptor-ships.